

# Reconstruction of superior mesenteric artery by prostheses placement in a case of chronic mesenteric ischemia: A case report and literature review

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**Abstract.** Although superior mesenteric artery stenosis is a relatively common situation, it is rarely symptomatic due to the fact that in a significant number of cases an adequate collateral circulation exists. The aim of this study is to report a case in which arterial reconstruction was needed due to the absence of such a patent collateral circulation. The 47-year-old patient was investigated for chronic postprandial pain and was diagnosed with superior mesenteric artery stenosis. Percutaneous treatment was the initial option of choice but the patient rapidly became symptomatic again. Therefore surgery was performed,

the segment of arterial stenosis was resected and the arterial continuity was re-established by using a synthetic prosthesis. The postoperative outcome was uneventful, the patient was discharged in the seventh postoperative day under anticoagulant therapy. In conclusion, superior mesenteric artery reconstruction by using a synthetic prosthesis can be useful in cases presenting chronic mesenteric ischemia and failure of percutaneous treatment.

## Introduction

Although superior mesenteric artery stenosis represents a relatively frequent pathological condition with increasing prevalence with age, it rarely becomes symptomatic due to the fact that most often the presence of an adequate collateral circulation will prevent the apparition of chronic mesenteric ischemia (1-3). Symptomatic chronic mesenteric ischemia was initially described at the end of the eighteen century (4,5), while the first surgical approach was described more than 50 years ago (6,7). At present, the main options of treatment are represented by endovascular and open approach. While endovascular surgery is usually less invasive than open surgery, being the initial option of choice in a significant number of cases, its results might be less durable and open approach might be needed if

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*Abbreviation:* PTFE, polytetrafluoroethylene

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symptoms reappear (8-10). The present study report a case of a 47-year-old man in whom re-appearance of symptoms after endovascular treatment imposed performing an open approach. Approval for the publication of the data was obtained from the Medical Ethics Committee of the Fundeni Clinical Institute (no. 28/2020; Bucharest, Romania) and written informed consent was obtained from the patient prior to the study.

### Case report

The 47-year-old male with no significant health history was investigated for postprandial abdominal pain, with onset within the first hours after meal which had been observed by the patient three months previously and progressively accentuated. According to the patient's description, the onset of the pain was usually within the first hour after ending the meal, while the duration was of one to one and a half hours. Moreover, a weight loss of 10 kg in the last three months was also associated and was rather explained by the patient's fear of eating in order not to induce the development of the abdominal pain. The patient was further submitted to an upper abdominal gastroscopy, which demonstrated the presence of diffuse chronic gastritis, and to a lower digestive endoscopy which failed to demonstrate any cause for this symptomatology. When testing which type of nutrients induce this type of pain, the gastroenterologist observed that the peak of intensity was induced by the administration of fatty nutrients.

The computed tomographic angiography demonstrated the presence of a stenosis of the superior mesenteric artery at 0.5 cm from the aortic origin, measuring 1 cm in length, which exceeded 75% of the mesenteric caliber with no other pathological aspects. Due to the fact that the patient was intensely symptomatic and due to the presence of these radiological findings, he was initially submitted to a percutaneous dilatation by using an endovascular balloon; although initially the postprandial pain diminished, the symptoms reappeared within the first six months, so the patient was considered as a candidate for surgery. The superior mesenteric artery was dissected and the stenotic segment was resected; the continuity of the superior mesenteric artery was re-established by placing a Dacron prosthesis which was implanted at the level of the abdominal aorta and was anastomosed with the stump of the mesenteric artery (Figs. 1-3). An intraoperative Doppler ultrasound was performed and demonstrated the presence of a good blood flow at the level of the synthetic patch. Intraoperatively, heparin treatment was initiated, and replaced during the early postoperative period with low molecular weight heparin. The postoperative course was uneventful the patient being discharged in the seventh postoperative day.

### Discussion

Superior mesenteric artery stenosis reports an increasing prevalence with age, from <6% in patients younger than 40 years of age to >65% among patients >75 years of age, these data being comparable to those reported so far for other peripheral vascular diseases, such as coronary or cerebral ones (11,12). However, while in cases presenting cardiac or cerebrovascular disease the development of ischemic events is a common eventuality being reported in up to 20% of cases, patients

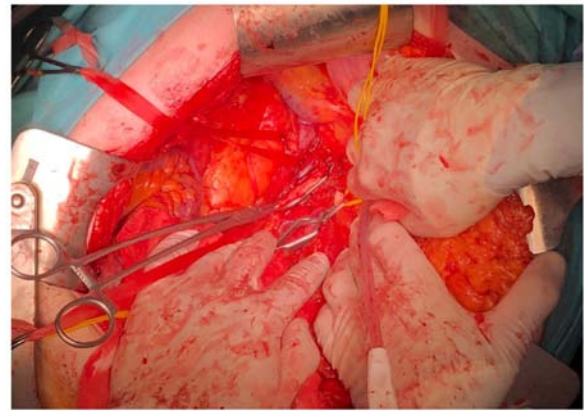


Figure 1. The aspect after identification and mobilization of the stenotic segment of the superior mesenteric artery.

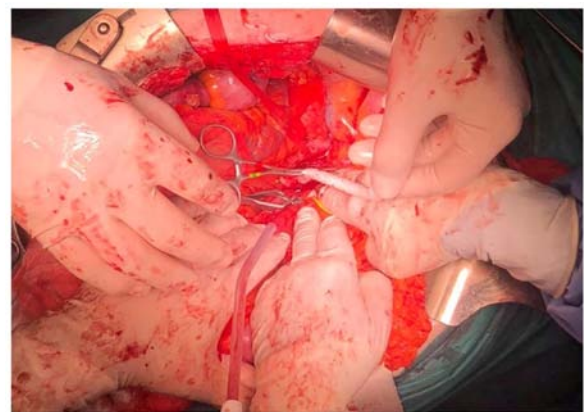


Figure 2. The aspect after resection of the stenotic segment; the continuity of the superior mesenteric artery to be re-established by placing the Dacron prosthesis.

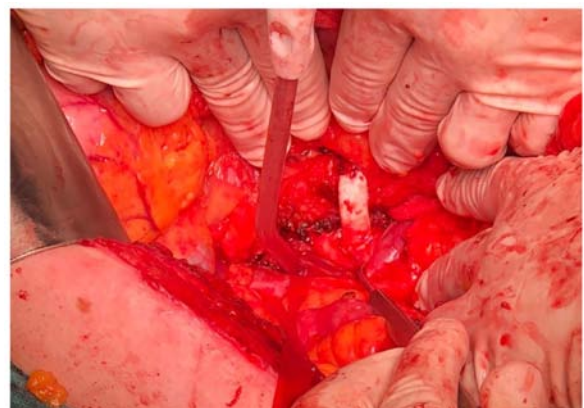


Figure 3. The final aspect after reconstruction of the superior mesenteric artery by Dacron prosthesis placement.

presenting superior mesenteric artery stenosis this situation is scarcer, being reported in up to 5% of cases. This fact is rather explained by the presence of a rich vascular anastomotic system which is developed at the mesenteric level and which provides a good collateral circulation as well as the delay in the appearance of clinical symptoms (2,13). According to the study of Someya *et al* (14), the baseline flow at the level of

superior mesenteric artery is 400 ml/min and increases up to 800 ml/min at 40 min after a meal, this increased value persists for up to 3 h. In this respect it is evident why the presence of a significant decrease of the blood flow at this level in the absence of a patent collateral circulation will become intensely symptomatic and will impose performing the procedure of revascularization.

In the last decade, due to the improvement of the endovascular surgical techniques such patients are initially considered to be candidates for percutaneous endovascular approach of the stenotic segment, consisting of femoral or brachial artery puncture, performing an angiography and re-permeabilization of the affected segment by using a dilatation balloon or by placing a stent (15,16). The main indication for such procedures is represented by the presence of symptomatic ischemia inducing weight loss and severe post-prandial pain (17,18). Most often, patients who benefit from percutaneous endovascular procedures present close to the aortic emergence lesions, with low length of the stenotic segment; whereas, patients considered as candidates for the open approach are usually those presenting more distal and extended lesions as well as those who return with failure and re-appearance of symptoms (19). However, while in cases submitted to percutaneous endovascular treatment restenosis and the need of reintervention is a common event, open surgery provides a significantly better chance for obtaining a durable result (10).

In the last decade, due to the improvement of surgical techniques, reconstructive procedures have been successfully used in patients presenting both benign and malignant abdominal conditions (20-27). In cases presenting benign conditions, different therapeutic strategies have been considered, such as replacement of the affected segment by placing an autologous or synthetic graft, or performing a bypass procedure (20,23-25,27).

One of the first studies which came to demonstrate the effectiveness of reconstructive surgery for atherosclerotic occlusive disease affecting the superior mesenteric artery was conducted between 1975 and 1988 in Hospital Saint Joseph, Paris, France (28). In this study the authors introduced 103 patients with a mean age of 57.2 years, 20 of them being submitted to surgery for chronic, typical abdominal angina. During the early postoperative period, four cases experienced early re-occlusions, while after a median follow-up period of 69 months, further five cases presented recurrent mesenteric ischemia. Among the 103 cases there were 10 patients presenting isolated superior mesenteric artery stenosis, four of them being asymptomatic at the time of surgery, other four cases presenting nonspecific abdominal symptoms, one case presenting typical abdominal angina and another case being already submitted to surgery and intestinal resection for intestinal ischemia. Moreover, seven cases associated superior and inferior mesenteric artery stenosis, 24 cases associated superior mesenteric artery stenosis and celiac trunk stenosis, while the remaining 62 cases presented stenotic lesions in all the three vascular territories. Therefore, superior mesenteric artery reconstruction was performed as stand-alone procedure or in association with other vascular gestures in all 103 cases. Most often, revascularization was provided by performing a bypass; however, in 14 cases, resection and reconstruction was performed, in nine cases the superior mesenteric artery

being reimplemented by using a prosthetic graft [in five patients a Dacron prosthesis was used while in the remaining four cases a polytetrafluoroethylene (PTFE), graft was the option of choice]. During the early postoperative period, none of these cases experienced any significant complications; during the late postoperative period five cases reported the appearance of ischemic complications; however, none of these cases had been submitted to reconstruction using Dacron prosthesis (28). Similar results were published three years later by the Danish study group conducted by Christensen *et al* (29) on 90 patients with atherosclerotic disease of the mesenteric arteries. Among these cases, there were 87 patients who necessitated the reconstruction of the superior mesenteric artery alone or in association with the celiac axis and/or with the inferior mesenteric artery. Superior mesenteric artery was reconstructed using a synthetic graft in 39 cases, Dacron prosthesis was placed in 36 cases and a PTFE graft was the option of choice in the remaining five cases. As for the postoperative outcomes, both early and long-term outcomes seemed to be significantly influenced by the indication for surgery, patients presenting acute intestinal ischemia at the time of surgery, reporting a significantly poorer outcome when compared with those presenting chronic lesions (29). As for the preferred techniques of arterial reconstruction by decade, Lejay *et al* (19) demonstrated that at the beginning of the 20th century prosthesis placement gained more popularity and provided better long-term outcomes when compared with other procedures such as bypasses; moreover, the authors underlined the fact that in a significant number of cases in which the endovascular treatment fails open surgery might provide a long lasting, durable revascularization of the affected territories.

In conclusion, although superior mesenteric artery stenosis is a common finding, situations in which revascularization for chronic abdominal pain is needed are rare; in such cases, the initial option of choice is represented by endovascular procedures such as balloon dilatation or stent placement. However, in certain cases presenting distal, prolonged areas of stenosis, percutaneous maneuvers might fail and open surgery might be needed. In such cases resection of the stenotic segment followed by prosthetic placement is demanding, but a very effective procedure.

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## Availability of data and materials

All data and images included and/or analyzed during the current study are available from the corresponding author on reasonable request.

## Authors' contributions

VB and DR performed the surgical procedures. CD and LI were responsible for the preoperative investigations and made

the diagnosis. NB, CoS, IB, OB, CaS, AN and BS performed the literature research regarding vascular techniques of re-permeabilization and reconstruction, and drafted the manuscript. NB reviewed the final version of the manuscript. All authors read and approved the final version of the manuscript.

### Ethics approval and consent to participate

The Medical Ethics Committee of the Fundeni Clinical Institute (no. 28/2020; Bucharest, Romania) approved the study and gave consent for the publication of the data. Written consent was obtained from the patient regarding participation to the study. Data collection was carried out during hospitalization.

### Patient consent for publication

Signed informed consent was obtained from the patient on 23.03.2020.

### Competing interests

The authors declare that they have no competing interests.

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